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HOSPITAL WORK WITH THE AUSTRALIAN IMPERIAL FORCE IN THE MIDDLE EAST.[1]

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THIS story can only truly be that of the First Australian General Hospital, with which my experiences chiefly lay. It cannot do a fraction of justice to the work of all the Australian hospitals in the Middle East. The First Hospital had less of the highlights of adventure than some, but less frustrations; it was able to work in a settled area, to attain a size well over three times its nominal bed capacity, and to treat many more patients than any other hospital. Many times would its staff have cheerfully exchanged with others, who had greater perils and greater difficulties; in some ways I still feel that its contribution has been all too small; but nevertheless the chronicle of this unit should be of some historical interest.

Leaving Australia with the original Sixth Division of the Australian Imperial Force on January 10, 1940, the First Australian General Hospital assembled its personnel in rather a scramble of haste, and more or less completed its equipment through the efforts of a buying commission during the week prior to embarkation. It is amusing to recall that in their innocence the officers took with them only such personal luggage as could be carried in a trunk and a suitcase, with no stretcher and no bedding. The mess equipment was correspondingly Spartan. Like subsequently formed medical units, we found a great advantage in sailing as an almost complete unit, although most of the nurses had to travel on a separate transport. This gave opportunity for daily lectures for officers and men, and before the contingent had received the personal welcome of Mr. Eden on its arrival in the Middle East we were firmly bound by the welding influence of work, understanding and companionship.

It was with some disfavour that on February 13, 1940, cold, stiff and dusty after a tiring night journey, we first looked upon the hospital site at Gaza Ridge, which consisted of ploughed fields intersected with several well-made roads and dotted with a few buildings. There were messes for officers and nurses, "ablutions" and latrines, a men's kitchen, a large hospital kitchen (which was used for general storage for several months), and for some obscure reason a sick officers' mess. The last-mentioned proved useful; it soon became the orderly room and pharmacy store, dental surgery and, later, temporary X-ray room, even though absence of blinds forced the radiologist to do his screening at night. Tents had been erected on the tenacious mud of Palestine by the Hampshires, our fostering regiment, and under a bleak sky a bitter wind blew over an area which we hoped would be only a temporary resting place, but which was destined to be not only permanent, but the largest and perhaps the most important Australian hospital site in the Middle East. It is interesting to recall that security regulations were strict. There was considerable restriction of movement; we were supposed to be off the roads by 5.30 p.m.; armed guards were placed on all transport, and our own men in pairs, armed with sticks, patrolled the camp site at night. The more wakeful members of the unit complained that sleep was not aided by the howling of jackals, which used to come right up into the area at night, or by the stumbling steps and richly adjectival converse of our guardians.

A small camp hospital was started at once, and accommodated our own sick and an odd man from adjacent units. Some medical work was done from the beginning, but patients needing investigations or surgical treatment were passed on to the British General Hospital at Sarafand. The official date of the opening of the First Australian General Hospital was some six weeks after arrival, when a number of wards were ready on both medical and surgical blocks, though as yet no operating was done. The tents available for wards were mainly "hospital marquees large".

[1] Read at a meeting of the New South Wales Branch of the British Medical Association on April 30, 1942.

The hospital personnel soon learnt how to erect tents, if they did not know already, and small gangs of Arabs were also coopted. Some of our medical officers became very expert officers commanding tents, and indeed there was not one officer in the whole unit who at some time or other did not help in this work. Even in May, when the personnel of the Second Australian General Hospital arrived, their officers' tents were personally erected by the officers of the First Australian General Hospital in the intervals of running the hospital. Nurses prowled round the area picking up precious tins, and bits of wire and board for the manufacture of Heath-Robinsonian contrivances in their wards. The first anæsthetic was given with a mask hastily contrived out of wire and soldered by the dental officer; proper masks were there, but somewhere hidden in a mass of unopened cases. The water supply was good and ample, coming from deep wells and bores, and was piped to the wards, though for a time water had to be carried in buckets to several wards from common standpipes. The quality of the water was not improved by a high mineral content, which readily furred cooking vessels, or by chloramination, which was said not to vitiate the flavour; but all the same, it took courage to drink the tea. It is of interest that there must be a definite fluoride content of some of the well water in coastal Palestine, judging by the characteristic effect on the teeth of the Arab children. This was noted by dental officers to occur in some localities. Heating in the wards depended on "Primus" stoves. This heating problem agitated us throughout our history. "Primus" stoves were precious as gold, and equally scarce, though it was sometimes possible to buy them even in Gaza when the Army could not supply them. At one time we allowed discreet quantities of beer to be bought by approved patients to be consumed with the midday meal, and the sale of the bottles provided ward funds which bought a number of useful articles, including "Primus" stoves and spare parts. Methylated spirit for starting the stoves was a rare essence and was firmly rationed. After a time we procured "Coleman" stoves, but the available supply of white petrol ran out and there were no spare parts. "Buta" gas was used in the main kitchen and was very satisfactory. This was later supplied to the wards also, with gas rings, but unfortunately enemy action limited the supply and we fell back again on the despised "Primus". Outdoor stoves were limited by the scarcity of fuel in treeless Palestine. Electric light and power later were brought into the wards, and some heaters were provided, which helped considerably. But often the nurses were hard put to it to supply with two "Primus" stoves hot water for washing, minor cooking and sterilization in a ward of from 70 to 80 men. As the hospital grew, diet trays heated with hot water were for some time not available in sufficient numbers, and food needed reheating. These difficulties were accentuated by the cutlery problem. You may imagine how few soldiers, especially those from a battle zone, brought in their own cutlery and how many secretly marched out with knife, fork and spoon belonging to the hospital. Occasionally some 20 full sets only could be mustered for 70 patients, but the nurses managed somehow.

Accommodation.

Originally hospital marquees were erected on the bare ground, but an obliging "red hat" from a British force decided that we must have concrete floors, so we had to move all the wards while this work was carried out. The date coincided with the arrival of the second convoy in May, 1940, and as a large crop of respiratory tract infections doubled our numbers within forty-eight hours, there was a trifle of scrambling to house the "admissions". I recall being uneasy that we might need another ward, and after obtaining permission to have this prepared, feeling amused and relieved as a little later I watched nurses admitting patients at one end of a marquee while at the other end Arabs stamped down the earth floor. Many a ward we had on earth floors. The concrete-floored marquees were very comfortable, especially when electric light was available. After Italy entered the war a complete blackout was ordered, and this offered many problems of lighting wards at night. However, all these difficulties were overcome by cooperation, constant policing and the exercise of a little good humour.

Plans were approved for a 600-bed hospital housing all patients and personnel in huts. In order to enable the contractors to work, the wards were again moved and the entire medical division was removed to a site half a mile from the nurses' quarters. We ran an omnibus service for the nurses, a very welcome help in the early rains of November and December, 1940; but the time-table was not often convenient for the medical officers, who developed a fine heel and toe style. Telephones were now less rare than in the early days, when running and shouting were substitute methods of communications. The running method does not always apply to the messengers optimistically called "runners". These new huts were very comfortable. They were silicate brick up to sill level, to give protection against flying splinters, and above this were wood uprights with panels of plaster based on wire. We remarked that it would be easy to put a foot through these walls; this was afterwards proved by some of the psychiatry patients. The wards were floored with tiles and lit with electric light. There was a sanitary annexe designed for a conservancy system. Hygiene was a difficult problem. Originally Otway pits were installed, but these functioned only as desiccating pits, and were not free from nuisance. A system of incineration was evolved, which was ideal for dysentery wards. Fly-proof boxes covered with hessian were made with sections marked for clean and dirty pans. Orderlies placed the pans in the box, from which these were removed by an Arab sweeper, who burnt the fæces with sawdust in a home-made incinerator, flushed the pans in a cyllin bath and boiled them in a "Soyer" stove, finally replacing them in the clean side of the box. This plan was later modified, and boiling was used as a method of destruction, because sawdust became almost unobtainable. A special boiler was made locally and worked well; but previous to this extemporized methods contrived by the hygiene section were satisfactory. They used a mud brick fireplace and a flash burner fed by a mixture of sump oil and water. An embargo on native labour caused further difficulty.

The hutted wards worked very well, and we were glad they had verandas, because we were forced to put beds on them to cope with the numbers of admissions. Before the new buildings were occupied they were too small, and soon after they were all in use early in 1941 the numbers were over 800 beds. Before long we were up to 1,200 beds and then to 1,500. The greatest rush came during the Syrian campaign, and even though temporary permission was given to raise the limit to 1,800 beds, we were constrained to overstep the official limit and had for a time 2,050 beds equipped. This meant a reversion to tents, even after all other wards had been crammed to the limit. Chinatown, as we called our hastily equipped rows of tents used during the Syrian campaign and for some time after, was not an inspiring sight, with its dusty floors and low barrack beds; but at least it helped field units north to evacuate their casualties promptly. Later in 1941 new wards were provided to house 1,500 patients, but shortage of materials necessitated the use of tents on concrete tiled floors, with separate hutted annexes containing provision for ablution and sanitation and also day rooms. These tents should have been expanding hospital marquees, but the great drain on tentage accentuated by losses in Greece forced us to use "E.P.I.P." tents strung together eleven in a row, accommodating 60 to 66 men. Individually these are excellent tents, but they cannot be made waterproof *en bloc*. In the violent rains of this last winter some wards became untenable. Buildings to house operating theatres, plaster room and X-ray department had been given priority of erection, and excellent brick buildings were provided. These units were all under one roof. Near by was a spacious pathology department, to which a small animal house and compound were added. Animals were a difficulty; guinea-pigs did not flourish well and were scarce; but a sheep and a donkey were on strength. Unofficial fauna, such as snakes,

lizards and chameleons, also lived in the department as pets or at least guests, and sometimes caused a little dismay to visitors.

Other Australian hospital accommodation in Palestine was limited for some time. The staff of the Second Australian General Hospital arrived in May, 1940, and lived in quarters adjacent to the First Hospital till the end of the year. They were usefully employed in assisting in hospital work (they took over infectious diseases and psychiatry wards in the First Australian General Hospital for some time), in supplying medical officers to other units, and in doing medical board work; but their hospital at El Kantara was not ready till late in 1940. They were then able to deal with Libyan casualties after these had passed through Australian forward units and sometimes through other British hospitals, and handled a great volume of work most efficiently. As will be noted later, special facio-maxillary and orthopædic units were later established at the Second Hospital. The staff of the Third Australian General Hospital was made up of personnel diverted to England, but it never functioned as a hospital in the Middle East. The Fourth Australian General Hospital did distinguished work in Tobruk, where in two sections it carried on with striking zeal and capacity without nurses. The Fifth Australian General Hospital lived for some time near the First; indeed, for a brief period the First, Second and Fifth Hospitals lived together at Gaza Ridge. Later the Fifth Hospital staff went to its site at Kfar Balu near Rehovot in central coastal Palestine and started to run its 1,200-bed hospital. The personnel had worked for only a little over a month when they packed up and departed on the tragic Grecian venture, where some of the medical and orderly staff and all equipment had to be left behind. Later, after reequipment, the Fifth Australian General Hospital went to Asmara in Eritrea to run a subacute diseases hospital, but for various reasons little work could be done and the unit returned to Palestine. The Sixth Australian General Hospital also came to Gaza Ridge for a time, and also departed for Greece, where at Volos the staff opened a tented hospital, but had to evacuate forthwith. The Fourth and Sixth Hospitals, after the former had come out of Tobruk, took over British hospitals (Sixtieth and Sixty-second) in Jerusalem. Here, in very pleasant surroundings, these units began to work at the end of the summer of 1941. The Seventh Australian General Hospital came up to the site vacated by the Fifth, and by hard striving contrived to have a hospital running in time to receive casualties from Syria. There were no general hospitals in Syria and the whole brunt of the Australian hospital work of the Syrian campaign, which was medically and surgically sharp enough to impose some strain for several months, was borne by the First and Seventh Hospitals. The Eighth was a special hospital for venereal disease, situated at Gaza Ridge. The Ninth Hospital, established at Nazareth after Syria was stabilized, and taking British and Australian sick, eased the general strain considerably. The Eleventh Australian General Hospital was a small 200-bed unit specially formed for work at Alexandria, and did excellent work.

These brief references in no way do justice to the fine work done by these hospitals, and of course no attempt can be made here to describe the splendid service rendered by the forward units, field ambulances and casualty clearing stations.

The problems of rapid expansion of a hospital are very great, especially in a small country like Palestine, where purchasing facilities are limited. To anticipate requirements, prepare ward sites, erect tents, secure beds and equipment, feed, nurse and care for the extra sick and wounded—these are considerable tasks for all branches of the personnel. It is worth recording as a personal experience of the staff of the First Australian General Hospital that, during the most hectic months of 1941, in the middle of the incessant and unvarying summer of the Middle East, when ordinary admissions and all work were heavy, and when special convoys were arriving every second night in addition, there was never heard a grumble or a complaint.

Organization.

We found it most necessary to keep our organization to some extent fluid, so as to allow for changes in equipment and situation. At the First Australian General Hospital each day began with a brief conference between commanding officers, officers commanding medical and surgical divisions, registrar and quartermaster. Here all matters arising out of correspondence or the day's work were reviewed, plans were laid, ideas were discussed, and perhaps most important of all, a general acquaintance with all phases of the unit's activities was gained by all. Thus all senior officers were familiar with affairs of administration, which helped the smooth running of the command in the absence of the commanding officer. Actually this unit carried on during the busiest two months of its existence without a commanding officer. The officers commanding medical and surgical divisions were, under the commanding officer, entirely responsible for their divisions. They had their own allotted staff, which varied somewhat according to the needs of the hospital, and posted their general duties officers where they wanted them. It will be noted that, subject to approval of the commanding officer, medical officers were not allotted to wards by the registrar, but by officers commanding divisions. These two officers also supervised the work of their divisions and looked over the equipment facilities and supplies, thus keeping a check on many details that cannot well be overseen by quartermaster and dispenser. In the medical division the medical specialists (of the rank of major) were not necessarily allotted wards; they were rather used in a supervisory capacity, the general principle being that all patients were seen by two medical officers. They also assisted in consultations and carried out or supervised special procedures, and knew the patients in the wards they overlooked well enough to be able to take over in case of the illness or absence of the ward medical officer. The pathology department was for purposes of administration included in the medical division; this was useful in the organization of work imposing strain on the department, like the investigation of pyrexias.

The officer commanding the surgical division controlled all surgical activities. He thus could regulate such matters as the balance of non-urgent admissions to ear, nose and throat and eye wards with more urgent surgical cases, and the distribution of some of the specialized work in orthopædic and general surgical wards. The orthopædist controlled all massage and physical therapy in addition to his ward work, organized a special foot clinic and ran chiropody courses. In general, each specialist did his own work as he wished; but close cooperation welded all these departments into an integrated whole. The ear, nose and throat and eye surgeons conducted outpatient clinics and worked very hard. Officers and nurses who were ill were as a rule looked after by the officers commanding divisions. In both medical and surgical departments it was found practicable to regard little groups of junior medical officers as teams each headed by a more senior officer, and this worked very well.

It may be said that the coordination of the work of the hospital was most satisfactorily accomplished, the principal factors being the harmonious personal relations of all senior officers and the avoidance of overlapping on the one hand, and too strict a limitation of duties on the other, by mutual understanding and by daily discussion of difficulties and arrangement of details of work at morning conferences. A good registrar is an invaluable person in a military hospital. At the First Australian General Hospital he was responsible for all records, returns and correspondence, supervised arrangements for admissions, and, acting in concert with the commanding officer and officers commanding divisions, organized general matters to do with the needs of accommodation, and smoothed out difficulties in ward routines. One medical officer was employed as company officer. Later a combatant officer was attached as camp staff officer; he was able to take over some of the company officer's duties, thus enabling the latter to do some clinical work. The work of orderly medical officer was shared by the general duties officers. There was no adjutant.

All patients for discharge to base depot or to convalescent depot were paraded before the commanding officer or his deputy every day. The records were sent to the orderly room by noon on the previous day. The commanding officer briefly "sized up" each man, glanced at the records and signed the discharge slip, adding any necessary comment for enlightenment of the man's unit. This task

FIGURE I.
First ward erected and used at the First Australian General Hospital.

was a rather weary routine in busy times, but it was amply justified. It increased efficiency, and the commanding officer was in this way made able to keep in touch with the work of the hospital, although he also went round the whole area or the greater part of it each day. We were fortunate in having most capable commanding officers, who, while maintaining a firm direction

FIGURE II.
Revetting of hospital marquees with mud bricks.

of policy and discipline, knew also the art of delegation of authority.

Records.

Records are always a curse to hospitals. Paper was extremely scarce; this imposed some limits, perhaps fortunately. Most of our histories were latterly taken on A.F. 1220 only, A.F. 1237 being reserved for detailed statements, transfers to hospitals or information for medical boards. Convalescent patients did not have temperature charts marked up, in order to save time and paper. Diet sheets were used for a time, but were later abandoned, except when special diets were needed. A master chart of diets in each ward was checked by the medical officer daily as required. Dispensary books for

FIGURE III.
Wooden type ward with sand bag protection.

prescriptions were used; no duplicate forms were written out. Treatment was entered on the history card. Supervision of the wards ensured that at least adequate records were kept; but we all slip in this respect at times, so some of the records made in busy times were perhaps rather thin. Field medical cards were carefully watched to ensure that the summary of each man's medical pilgrimage was correctly set down.

FIGURE IV.
Operating theatre block.

Medical Boards.

Medical boards were initiated in the Australian Imperial Force in the Middle East by the First Australian General Hospital; at first the British Royal Army Medical Corps forms were used. These gave us some trouble at first; but when the personnel of the Second Australian General

Hospital arrived in May the whole organization was handed over to them as a "going concern". Permanent or at least semi-permanent officers were appointed later to medical boards, and these, chiefly from personnel of the Second Australian General Hospital, evolved an excellent set of routine methods. Australian Imperial Force boards worked very carefully; it was found that a board of two, working day after day, could see a maximum of only up to 10 to 12 men per day. All "D2's" were approved by the Assistant Director of Medical Services or other competent authority before coming to the board, and careful records of history and examination were made in detail. Unfortunately it was impossible to avoid large waiting lists, because the number of boards available was not sufficient.

Nature of Work Done.

Medical.

The preponderance of work in the hospital was usually medical, and the range of this purely medical work was great. Infectious disease became so common for a time that a separate subdivision was formed, and the senior medical major of the First Australian General Hospital ran this as a separate subcommand. Numbers of men suffering from cerebro-spinal meningitis were treated at this time, and the remarkable results obtained even among the desperately ill patients were due not only to the effects of sulphapyridine, but also to the focused energy

FIGURE V.
Sanitary annexe made of mud bricks.

of the staff and its tireless zeal. Injectable "Dagenan" was almost unobtainable, and I have no doubt that lives were saved by the devotion of medical officers, who rose at regular hours during the night to administer the drug by duodenal tube. All exanthemata were met with, and the usual run of other infections. Infective hepatitis was not uncommon. It was occasionally severe, and in the pre-icteric stage it offered a nice problem for diagnosis. This virus disease, which is transmitted in some obscure way, is common in northern Palestine and Syria. We saw no spirochætal jaundice. Glandular fever occurred and was occasionally protracted. Typhoid and paratyphoid were very uncommon, but severe when they occurred, especially in a few cases among Greek airmen. Undulant fever was also rare. Bacillary dysentery was extremely common, but was usually mild, and was not a serious menace. Its concentration in certain units as contrasted with others illustrated the value of rigid hygiene. We always had a dysentery ward throughout the year, and in peak periods filled several wards. A good many cases of toxic dysentery were seen, but there were only a few deaths over a period of eighteen months. Complications were sometimes seen—ocular, fibrositic and arthritic. There were a fair number of Shiga infections, mostly quite severe. These were usually suspected from the high grade of toxicity and the persistence and increasing severity of symptoms, due to the gradually spreading necrotic changes in the mucosa of the colon peculiar to this disease. Peripheral circulatory failure and dehydra-

FIGURE VI.
Brigaded tents on tiled base to accommodate sixty patients. Sanitary annexe *et cetera* on left.

tion are ominous signs. Special arrangements were devised in these wards for keeping specimens for daily inspection. The waxed paper cup was found convenient for pathological work, and for daily routine examination the flat tobacco tin was used. A routine of treatment was laid down, using magnesium sulphate or sodium sulphate and a diet graduated from fluids and monosaccharides to polysaccharides and then to proteins and fats and higher

FIGURE VII.
Interior of hut type of ward.

residue foods. Some trouble was found with patients who had been treated in their units with bismuth and opium for some days. This is not a good routine method for treatment of all patients suffering from diarrhœa, and it is very bad in a country where dysentery is endemic. Saline draughts and starvation are preferable and help to prevent long illnesses in these cases. Pain, if severe,

is best treated with morphine; in severe Shiga and Flexner infections it is nearly always required. Latterly sulphanilylguanidine became available, though only in small quantities at first. It is a most valuable drug. In dosage of 0·1 gramme per kilogram of body weight followed by half this dose every four hours it rapidly reduces the number of stools and improves their quality. Shiga antitoxin of very highly concentrated titre was available in small amounts. It helped to combat toxæmia and caused no ill effects. Ordinary antidysenteric serum was not used. The physicians used to warn the surgeons, with a mixture of caution and humorous cynicism, that it was necessary to ensure that a case of apparent acute appendicitis was not really one of dysentery. A few cases of gangrenous appendicitis were associated with dysentery, but the need for caution is real. An abdominal wound is an unhappy burden for the patient with severe Shiga dysentery to bear.

Amœbic infections occurred in regular but moderate numbers. A good protozoologist was invaluable here, though proof is not always forthcoming, and it was necessary at times to try the use of emetine diagnostically as well as therapeutically. This, of course, applies particularly to hepatic abscess.

Pneumonia was not formidable, though we saw many cases, and the need for economy in sulphapyridine showed us that patients treated with this drug do not always need massive doses. Acute middle ear disease was common with the upper respiratory tract infections, and the help of a skilled otologist was most welcome. Diphtheria was not uncommon and occasional sequelæ were seen.

Virus infections of the central nervous system were not infrequent. Mumps meningitis and meningo-encephalitis occurred in a number of cases, also benign lymphocytic choriomeningitis. Poliomyelitis was seen in a few cases, also diffuse encephalomyelitis. Drop-wrist and drop-foot occurred in a group of cases in which the evidence pointed to a lesion of the type of the so-called infective polyneuritis. These and other more severe forms of motor paralysis due to an infective cause were possibly related to the type distinguished by an increased protein content without an increase in the number of cells in the spinal fluid. Relapsing fever added to the interest and difficulties of diagnosis of nervous diseases, for cerebral sequelæ occurred in a number of cases. This treponemal infection occurred in Libya and Syria, and to a less extent in Palestine. It was all tick-borne, and the infection was acquired in caves in most cases. The tick bites usually became reactivated during each bout of fever, and in one case a man was actually sent in with a provisional diagnosis of "papular dermatitis". The organism was often hard to find in the blood. It is subject to many variations of type; unfortunately the strains we encountered were completely resistant to arsenic. No treatment was found to shorten or modify the course of the disease. I am not sure that all the cerebral sequelæ will resolve without trace; much clinical material was collected in Palestine, particularly by the First and Seventh Hospitals, and it is hoped that these cases will be followed up.

Sandfly fever, a variant of dengue, had a high nuisance value during the summer months. It was temporarily prostrating, and sometimes the convalescence was delayed over a couple of weeks. Relapses in the same season are not common, but they occurred rather more often in 1941 than in 1940.

Malaria was not a serious problem during 1940, as few troops were in dangerous areas in Palestine, and almost the only cases occurred among men infected while on night exercises in infected zones. The Syrian campaign produced a great deal more, but the incidence was greatly limited by the splendid work of a little band of malariologists and hygienists in both British and Australian forces. A considerable problem was presented by the need for prompt examination of the blood of all patients with suspicious pyrexia. This was solved by the provision in every ward of an outfit for taking blood films and the instructing of all the nurses how to make thick blood films. These films were used only when identification of a parasite was difficult. The nurses were further authorized to take films whenever indications appeared and to send these promptly to the pathology department, with the appropriate form made out and signed for the medical officer if he was not available. They soon learned to put the slides away in a safe place where the flies would not devour the entire film. Slides were prepared on each of three successive days if necessary. I can see now the pathologist of the First Australian General Hospital, in spite of his being a patient in hospital himself with cellulitis of the leg, sitting beside his bed examining blood films all day, refreshing his weary eyes at intervals by reading the plays of Shakespeare. Australian Imperial Force routine treatment for malaria was the administration of quinine for about four days, till fever had abated, followed by seven days of "Atebrin" treatment (0·1 gramme three times a day) and five days of "Plasmoquine" treatment (0·01 gramme three times a day). The course stopped there, and relapses were dealt with if they occurred. Occasionally second or supplementary courses were necessary. We could not obtain ampoules of quinine for intravenous use, as these were reserved for more forward units; but this mattered little, as sterilized solutions were prepared with adequate safeguards. A number of dangerously ill patients were successfully treated. Probably it is true that quinine for intravenous administration is used not too much, but too little. Tuberculosis of the lungs was seen in a recent acute form in a limited number of cases; but there can be no question of the immense value of mass radiology of the chests of recruits. Digestive diseases were very common indeed, and many cases of duodenal ulcer were seen. Whether suffering from ulcer or not, some of the military patients knew the classic symptoms as well as a medical student. A rigid criterion of diagnosis was laid down, requiring clinical, radiological and chemical evidence, but it was difficult in every case to fulfil this. An X-ray examination was always made when the clinical findings warranted it; but economy demanded that it should not always be an invariable routine, for we were sometimes short not only of films but also of barium. Cardiac diseases, rheumatic and otherwise, were met with in small numbers. We had not the good fortune to have an electrocardiograph presented to the unit like some other hospitals, but were able for a time to have tracings made on a machine which had been given for the use of the Fifth Australian General Hospital. An electrocardiograph is chiefly useful in a hospital at a base in connexion with medical boards.

War neuroses formed an important group of disorders. Very early in the history of the Australian Imperial Force the whole question of psychiatry came to light. I am amused to reflect that in the early days I had to be the psychiatrist and dermatologist, though these specialties I have always avoided. For some time a score of men with psychoses and severe neuroses were nursed in tents by mental orderlies; eventually better quarters were obtained, and the personnel of the Second Australian General Hospital took this work over for a few months till they moved to their own hospital. Later, when new wards were built, one was specially designed for psychiatric patients, though a couple of energetic manic Diggers soon showed what they thought of the Palestine contractor's idea of a strongroom.

Men with acute neuroses arrived in large numbers from Syria. We strenuously resisted the terrible word "shell-shock", with its inaccurate connotation and unfortunate suggestion; but the even more terrible "bomb-happy" has now infected even the medical profession. A special committee met in 1940 at the request of the Director of Medical Services to draw up recommendations for the handling of such patients, and following the suggestions thus made the term "exhaustion" was used for men with acute neuroses who were expected to recover quickly. Other such disorders were called "anxiety state or neurosis" or "hysteria" as appropriate. The abbreviations "N.Y.D.N." or "N.Y.D.P." were sometimes used on field cards. The early cases of exhaustion did not necessarily occur among men subjected to close aerial attack, but there is no doubt

this is an important factor. Prompt and energetic treatment with sufficiently profound sedation and early encouragement to return to work produced excellent results. The worst and most prolonged cases occurred among men whose previous psychological background was unfavourable.

In the latter part of 1941 a full-time psychiatrist arrived in the Middle East and started a special unit close to the convalescent depot at Kfar Vitkin. Before this we had the advantage of having a commanding officer at the First Australian General Hospital who was a psychiatrist.

Skin diseases were very common. Tinea occurred in many cases, but only seldom among those who could take adequate precautions with changes of clothing and the use of a dusting powder. The dyes were valuable, but extremely difficult to obtain, even at a time when (as was found privately) they could be bought in the open market in Australia. There is no doubt that in some cases treatment was overdone. Further, many were not cases of tinea at all. That variety of eczema or dermatitis often starting like a dyshydrosis (the so-called chiropompholyx) and spreading over the fingers and hand, or the feet, also dignified with the name *"acrodermatitis perstans"*, was very common. Streptococcal or staphylococcal infections were added, and bacterial sensitivity seemed to follow. The so-called desert sores were troublesome. Occasionally cutaneous diphtheria was found and responded to appropriate treatment. The role of food deficiencies seems unsettled in these and other conditions. A small series of cases was investigated by the pathological staff of the Second Australian General Hospital to ascertain the body concentration of vitamin *C*, but no striking abnormalities were discovered. There is some reason to think that deficiencies of various components of the vitamin *B* complex occur; that they may be more likely to occur under certain military conditions than in civil life must surely be admitted. Numbers of cases of dermatitis believed to be allergic occurred; no doubt many of these may be suspected in the light of more recent knowledge to be due to chrome dye in clothing.

The appointment of a dermatologist to the staff of the hospital as a physician was made early in 1941 and was welcomed as an important step in the right direction. Indeed, First Australian General Hospital suggested the establishment of a skin centre to higher formations, and this would have been justified by the volume of work.

The pathological department was always busy; all branches of work were carried out, and the prompt and accurate work done was invaluable. For part of the time pathologists from other hospitals were attached to it, and it was evident that when the number of beds rose to over 1,000 the work was too heavy for one officer, even with good technical help.

Surgical.

We heard many stories of the difficulty or even impossibility of carrying out surgical procedures in the summer, but these were not founded on fact. Certainly in the Khamsin days, when the dust and heat were difficult to exclude, good facilities were needed. These were available in an excellent operating theatre block. Before the theatre was built a mobile theatre designed for a French casualty clearing station was erected for inspection, but it was not used, as it was not suitable for use in a base area. Meanwhile a staging mess just completed was commandeered and adapted as a temporary theatre. In spite of extemporizations, the surgeons did some valuable emergency work here. Once this division was in full swing all branches of work were done with success, including abdominal, thoracic, cerebral, orthopædic, urological, ear, nose and throat, and eye surgery. During 1941 a special thoracic unit was formed at the First Australian General Hospital and a special facio-maxillary unit at the Second Australian General Hospital, where also a special orthopædic centre was established. I am able to give no useful information about the military surgical work done at the First Australian General Hospital. As might have been expected, men with injuries to limbs formed a considerable proportion of those sent on, and as a spectator I was impressed by the immense value of plaster of Paris in these cases. The complete enclosure in plaster of these limbs undoubtedly helped forward units to evacuate patients early, and greatly ministered to their comfort. A whole ward was set aside for the more or less minor septic wounds. This whole subject is probably better left for discussion by those with first-hand surgical experience.

The officer commanding the surgical division rightly regarded the talents of his junior staff as assets to be encouraged, and excellent team work resulted. Difficulty was often experienced in obtaining special equipment, and repairs to instruments like cystoscopes were dependent on alien mechanics in the back streets of Tel Aviv. The orthopædic surgeon passed some anxious months hoping that no urgent need would arrive for the treatment of many fractured femurs, and hoping against hope that he would acquire workshop equipment. When the need really came it was met, and a great deal of that meticulous and patient work of the orthopædist bore worthy fruit. I cannot enter into the controversy about removal of a meniscus from a knee, but it must be admitted that not all of these operations were successful from the military point of view. In the early days orthopædic disabilities were far too common, but as methods of recruit examination were tightened up the position improved.

The provision of methods for the treatment of shock was gone into carefully, and a ward near the operating theatre was specially equipped; this proved of great value in the more severe surgical cases. No blood bank was kept, as facilities were lacking and donors were abundant. Pooled serum was available during the latter part of 1941; although only enough for a few patients was actually held at the First Australian General Hospital, adequate quantities were supplied to base depots.

The oxygen problem worried us not a little. The number of cylinders was limited, and Australia and Palestine seemed the only available sources of supply. Before base stores were thoroughly stocked and working, the anæsthetist and I journeyed to Haifa in a utility truck, taking cylinders to be refilled there with commercial oxygen. Later these anxieties were removed by local arrangements, and the anæsthetist persuaded an army field workshop to make a decanting device for filling small cylinders from a large one. Originally only three Haldane masks were possessed by us, far below our standard equipment; but later an adequate number of the excellent "B.L.B." masks were obtained by pooling of the resources of several hospitals. Previous to this, several queer home-made boxes and tents were devised and used for concentrating oxygen.

The eye surgeon encountered many cases of eye infections. He also found that many soldiers with refractive errors complained of glare, and he worked nearly all day over long periods making refractive examinations. The problem of army spectacles is not yet solved. Marvellous were the contract glasses supplied by one local firm; the cylinders could be persuaded to assume any angle and the frames any shape. Later the men desiring glasses quickly could claim £1 Palestine on "TS4" and buy the glasses from a reputable firm in one of the towns.

The anæsthetist undertook all arrangements about anæsthetics and cooperated with the officer commanding the medical division in releasing medical officers from operating theatres to carry out urgent ward work and, with the officer commanding the surgical division, in deciding what anæsthetic drugs were to be used, a matter of great importance when supplies were short, as they often were. He also assisted in the work in medical wards. A consultation service added to the labours of the hospital. It was found that some medical officers tended to refer problems they could solve themselves, so a plan was followed by which approval of consultations was sought from the Assistant Director of Medical Services before appointment was made. The number of patients seen on a given day was also rationed. Even so, the work was sometimes considerable.

The X-ray department worked hard and well. Supplies of drugs necessary for cholecystography and excretion pyelograms were usually scanty, so that careful selection

of cases was required, with confirmation of a senior officer. Barium meal examinations usually had to be made by screening only, because of the limited supply of films. It was found that one radiologist, given adequate technical assistance, could do the work for a hospital of 1,500 beds.

Supplies and Equipment.

Admiration must be felt for those who miraculously produced supplies for the whole organization when the need for rapid expansion came. It was necessary to have the ear of that important person "D.A.D.O.S.", and we were grateful for the prompt supply of urgent requirements, even though their quality was not always ideal. For example, the low barrack beds obtained from old British stocks were inconvenient and a bit unstable; but at least they were beds, even if they did contain bugs. This trial caused much activity with kerosene baths and blowlamps. It was inspiring to see convalescent patients assisting in the hunt. "D.A.D.O.S." did remark querulously that he had already bought us 1,500 sets of cutlery when we asked for more, and in this and many other things we often ran short; but, in the army phrase, everyone played wonderfully. Hospital laundry was done in Tel Aviv, and transport and worries over the smooth, or rather non-smooth, working of contracts caused some inconvenience at times. Food supplies were most reliable, though some foodstuffs were unobtainable at times, such as potatoes and green vegetables and fruit in adequate amounts. Milk was tinned powdered milk, except for a limited amount of fresh dairy milk of fair quality obtained for patients.

Equipment was often a trouble. We had left Australia hastily, and when we saw the possessions of other units we sometimes felt more than a trace of envy; but for working in the field de-luxe equipment is hardly expected. Besides, in compensation we had a lot of fun pioneering. There is always a tug-of-war over equipment. Units look hopefully for fairy godmothers, but find they are not on army establishment, and wonder why modest outlays are sometimes not approved even though they may in the end save money. At the same time, there are doctors both in and out of the army who need constantly to be reminded that a state of war means economy.

At the end of 1940 a pharmacopœia committee was appointed by the Director of Medical Services, Australian Imperial Force. This body, after considerable labour, drew up a Spartan formulary which met all local requirements, and compiled a list of drugs which included the minimum for all ordinary treatment and in addition every preparation desirable in tropical countries.

Training.

There is, of course, only one training school, that of hard experience. Nobody in a medical unit feels enthusiasm for working with part-trained or non-trained orderlies; but when necessity arose, as in the Fourth Hospital in Tobruk and in the field ambulances in Syria, where these functioned as hospitals, good work was done without nurses. It is difficult for sheer lack of time to train orderlies when a hospital in the field is busily at work. After the Grecian campaign the possibilities of small hospitals were explored. One very successful small hospital, the Eleventh Australian General Hospital, was established in Alexandria. This used nurses, but the idea was mooted of training orderlies to replace nurses in some sense, so that small hospitals could be kept in relatively forward areas. In modern swift-moving war nurses may constitute a difficulty which they themselves deny, but which exists, because no one wishes to see them prisoners of war. To supply some training to orderlies, and before the Australian Army Medical Corps training wing was fully in running order, a temporary unit was formed, the "nursing orderlies' instructional course", and intensive training was given to over a hundred men. I was given this strange unit as a command, and after a month's work with a staff of sister tutors it was disbanded and the promising orderlies were absorbed into active hospital work to complete their training. Some of these turned out very well, and in forward units in Syria did good work. I have remarked in connexion with this school that I probably held an Australian Imperial Force record for brevity of tenure of a command.

The Australian Army Medical Corps training wing was particularly useful in giving officers an insight into their responsibilities in army medical work and in instructing other medical personnel. Here a word may be said about the nurses. They did splendid work. An ability to handle men counts heavily in the army; nursing work is no exception to this. The same is true of adaptability of mind. I have watched with amusement and admiration certain nurses getting work done by orderlies and convalescents without a murmur, and have even wondered if I myself was being similarly "managed". It is also a great help to have nurses, and this applied with special force to the higher administrative grades, who know their place, their duties and their responsibilities in a military environment. One quaint habit of nurses is worth mentioning—that of hoarding. Once when we were very short of phenobarbital the dispenser and I raided the poison cupboards and obtained several weeks' supply for the hospital. But it is pleasant to be able to say that in general the Australian nurse is cheerful, highly competent, calm in adversity and resourceful to a degree.

Certain educational activities were undertaken at the First Australian General Hospital. Two successful and largely attended clinical meetings were held, and these stimulated the Hadassah Hospital in Jerusalem to start a series of monthly demonstrations for all service medical officers. The Australian Army Medical Corps owes a great deal to the staff of this organization for its interest and help in this and many other ways. The various medical units used to hold their own little clinics also when conditions permitted, and this helped to keep up the standard of work. Also at the First Australian General Hospital several series of lectures and demonstrations were given on tropical diseases and other relevant subjects to medical officers of neighbouring units. The First and Second Hospitals also combined as a hospital group before the Second started its own unit, and arranged fortnightly discussions on important topics. All these interests helped greatly to keep the standard of work high, and without any false modesty it can truly be said that it was high. The interest and help of the Director of Medical Services, Australian Imperial Force, Deputy Director of Medical Services of the corps, and the various assistant directors of medical services all contributed towards attaining this end. The Consulting Physician and Consulting Surgeon of the Australian Imperial Force were most helpful, and whenever they went on rounds of the various medical units they used to stay with them and thus enter into the atmosphere and spirit of the work.

The Work of Other Units.

Other medical units came into more or less close relationship with hospitals. I am not competent to speak intimately of the work of casualty clearing stations and field ambulances; but we who handled the patients passed on from them know how completely they did their work. Quick and accurate judgement were required to decide which cases, either medical or surgical, should be dealt with in forward units and which passed on; this difficult work was well done. The work of surgical teams, some of whose members were drawn from medical staffs, was often outstanding. Some of the younger surgeons did excellent work here. The First Australian Convalescent Depot was a hard-worked unit, which was sometimes pressed beyond capacity. Its cooperation made possible the work of hospitals at full strength during the busy periods.

The Medical Men Themselves.

Something should be said of the men themselves who worked in hospitals. The young men were usually sent out to field units, and the average age of the officers of the unit, which was never low, thus tended to rise. The

cheerfulness with which officers with high technical ability would undertake all manner of odd jobs was striking. Whether it was supervision of hygiene, "A.R.P." or the erection of tents, they cooperated well. Many hospital routines are intrinsically dull, and it takes some character to perform these well for a long period of time without losing zeal or morale.

The health of officers in hospital was perhaps not as undisturbed as we could have wished for. A hospital is often a centre of infection difficult to avoid; for example, an area such as ours presented many admirable breeding grounds for sandflies, and naturally the fever they carry attacked almost everyone. The climate was rather trying and monotonous, work was constant over long periods, and minor ailments were rather common. Looking back, I think that sometimes the work imposed a strain, and this was not lessened by frequent changes and shortages in staff. The health of nurses was on the whole good. They are not always an easy class of person to supervise from the health point of view; they have their own ideas occasionally, though of course they are not nearly so difficult as medical officers. It was made an obligation to report all minor maladies, but no official notice was taken of these if they proved unimportant, an informality which encouraged cooperation. But indications for admission of nurses to hospital were relentlessly followed, and adequate sick leave was insisted upon. At the end of the summer each nurse was reviewed separately, and in this way disabilities like nutritional anæmias were picked up. When the local conditions made periods of leave possible to nursing personnel, we pressed for this privilege. Sometimes this made us a little unpopular with the higher formations, but it was a policy that paid well. Leave for officers was also allowed as occasions permitted. It is not always easy to arrange, for whereas nurses can be sent away in batches, medical officers can be spared only one or two at a time as a rule, and they were sometimes at a loss to arrange a brief holiday at short notice. Most of our officers were able to see a good deal of the surrounding country in this way, though transport was a difficult problem. There were few amenities. Cinemas were erected in the larger camps, but this form of entertainment was not largely patronized by hospital officers. Other entertainments were provided in these centres from time to time, the most ambitious of these being concerts by the Palestine Symphony Orchestra, which is worthy to rank with some of the best orchestras in Europe. Sport was limited. Tennis courts were built for the use of nurses, and it was possible to arrange occasional use of one of these for medical officers. The beach at Gaza was a welcome diversion to those who had the time and opportunity, but it was some miles away, and while Red Cross transport was provided for patients and nurses, the officers had to make their own arrangements.

Conclusion.

As a general comment on hospitals, it has been amply proved that the mobility of a general hospital is limited. Yet in the latter part of 1941 it was curious to go from what was really a base hospital at Gaza, in spite of its many necessary extemporizations, to Syria after the campaign, where the casualty clearing stations and field ambulances worked as hospitals. Some of these units were here housed in palatial buildings designed for hospitals and schools, and their facilities far surpassed those of most of the general hospitals. But it shows that a small hospital, lightly equipped and relatively mobile, has distinct possibilities. Once again mobile laboratories proved their worth in forward areas.

In conclusion let me say that it was a great privilege to assist in the building and maintaining of a large unit which, though facilities and amenities were limited, was able to meet all reasonable demands of modern medical service. Further, it was a wonderful experience to be living on the ancient storied soil of Palestine, with opportunities of visiting Syria, Egypt and Transjordan. The history of the spread of civilization through the culture of the Egyptian dynasties and the colonizing and trading capacity of the Phœnicians is there to read; the impact of Judaism, Christianity and Islam on the world is here epitomized; and it was stirring to realize that once more in this little corner of the Middle East great events are taking place. In these surroundings it was impossible to feel important, which is a great advantage in itself.

The life was not all easy going. There was much hard work to be done, imposing both physical and mental strain; but as everyone knows so well who has done military work, the slack times were in some ways a sterner test of morale. At times we all were pervaded by an indescribable feeling, a strange compound of boredom, remoteness, unreality, and a loneliness which is not of the body but of the spirit. But, in spite of this, it is by living together and working together in a common cause that diverse personalities are welded in the truest sense into a unit.

The anxieties, beauties, frustrations, satisfactions and amusements of this experience form a richly emotional pattern of memory; but one of the highlights must always be the recollection of what it meant to work together.

Reports of Cases.

A LARGE DERMOID CYST IN AN ELDERLY SPINSTER.

By P. L. HIPSLEY, M.D., F.R.A.C.S.,
Sydney.

Clinical Record.

L.L., a single woman, aged sixty-three years, consulted me not because she was ailing in any way, but because certain of her friends had told her that she should see a doctor because she had "such a big stomach". She said that she felt sure there was nothing wrong with her, as she was in the habit of doing a considerable amount of gardening and had never felt any ill effects from this; but she thought it better to consult a doctor so as to satisfy her friends.

I found that she was a healthy-looking woman who had been engaged all her adult life as a school teacher. She had never suffered from any serious illness, and inquiries into her menstrual history revealed no abnormality. An examination of the abdomen revealed a tumour about the size of a full-time pregnancy.

A paramedian incision was made to investigate the nature of the tumour. It was thought to be a large ovarian cyst, and an attempt was made to evacuate the contents before its removal; but as these were semi-solid, the incision had to be enlarged from the *symphysis pubis* to the xiphisternum before it could be delivered. There were no adhesions and so its removal was a simple matter. Her recovery was uneventful. The cyst is illustrated in a figure on the following page.

Pathological Report.

The following is a report on the cyst by Dr. P. E. Walton Smith:

> Ovarian cyst weighed 31 pounds. Horizontal measurement twelve inches. Vertical nine inches. The cyst has a fibrous wall and contains a large quantity of brownish fluid and large masses of cheesy material with numerous short light-coloured hairs embedded in it.
>
> Microscopical examination. The wall is composed of fibrous tissue and shows the presence of congested thin-walled blood spaces and collections of inflammatory cells. Projecting into the cyst are teratomatous areas consisting of fibrous tissue with fat and numerous epithelial cells, the striking feature being the great proliferation of sebaceous cells. No cartilage or bone found. The cyst is a cystic teratoma (ovarian dermoid).

Figure showing cyst described by Dr. P. L. Hipsley in a report of case on the previous page.

Notes on Books, Current Journals and New Appliances.

A PICTURE OF AUSTRALIA'S WAR EFFORT.

A BOOK which Australians should take seriously has been written by Mr. George H. Johnston.[1] He has called it "Australia at War" and it gives a good description of the way in which Australians are tackling the job of defending their country. Though the book is incomplete in that it has to do almost entirely with the Australian soldier and with his backing on the home front in the manufacture of munitions, the reader will have no doubt that the determination to succeed that is shown by the army is just as great in the navy and air force. The people of this country ought to read this book in order to gain some insight into the magnitude of the task that has to be faced by the Commonwealth. The work seen by Mr. Johnston and described by him in convincing language will open their eyes. The book is worth reading for its description of road making in the central and northern parts of the continent if for no other reason. And the chapter "Soldiers Go Back to School" will make many who at present do not understand, appreciate the fact that soldiers are not made in a day, however willing, muscular and keen recruits may be. Mr. Johnston has done well to concentrate on achievement and on the spirit of cooperation shown by all branches of the service; faults are easy to find in any undertaking, and we have quite enough croaking pessimists in the country. Since nothing succeeds like success, this book is good propaganda and might with advantage be read by those who wrangle in industry to our general detriment.

[1] "Australia at War", by George H. Johnston; 1942. Sydney: Angus and Robertson Limited. Demy 8vo, pp. 284 with 36 illustrations. Price: 10s. 6d. net.

FIRST AID.

THE latest of "The Practitioner" Booklets to appear is one which consists of a series of articles on first aid.[1] These articles are intended for the doctor in general and in special practice, for every medical man today is liable to be called on to render first aid or to instruct non-medical workers in what they shall do in emergencies. Most of them have already appeared in *The Practitioner* and they bear the hall-mark of the editorship of Sir Humphry Rolleston and Dr. Alan Moncrieff. Most medical practitioners know instinctively what to do in an emergency, but some find it difficult to convey the information to other people; this book will help them. Others maybe are busy in special spheres and have not bothered to make themselves familiar with the emergency treatment of such conditions as burns, shock, head injuries, eye injuries and so on; this book will help them too. As E. Rock Carling writes in the introduction, skilled first aid attention is "gentle, precise, purposive, and swift although unhurried". And there is no doubt that ultimate recovery often depends on the way in which the immediate treatment after an injury is carried out. We can recommend this book to any practitioner in search of a first aid manual.

[1] "First Aid and the Medical Practitioner", by various authors, with an introduction by E. Rock Carling, M.B., B.S., F.R.C.S.; edited by Sir Humphry Rolleston, Bt., G.C.V.O., K.C.B., M.D., F.R.C.P., and Alan Moncrieff, M.D., F.R.C.P.; 1942. London: Eyre and Spottiswoode. Medium 8vo, pp. 108 with 9 illustrations. Price: 6s. net.

The Medical Journal of Australia

SATURDAY, JULY 25, 1942.

All articles submitted for publication in this journal should be typed with double or treble spacing. Carbon copies should not be sent. Authors are requested to avoid the use of abbreviations and not to underline either words or phrases.

Reference to articles and books should be carefully checked. In a reference the following information should be given without abbreviation: Initials of author, surname of author, full title of article, name of journal, volume, full date (month, day and year), number of the first page of the article. If a reference is made to an abstract of a paper, the name of the original journal, together with that of the journal in which the abstract has appeared, should be given with full date in each instance.

Authors who are not accustomed to preparing drawings or photographic prints for reproduction are invited to seek the advice of the Editor.

PREGNANCY AND DIABETES.

THE discovery of insulin made pregnancy for diabetic women a much less dangerous state than it had been. This was perhaps to be expected, but the added safety did not cover the fœtus—insulin has reduced the mortality rate among diabetic mothers to an almost negligible figure, but it has had practically no effect on the number of deaths among their fœtuses. The figures from Joslin's clinic have been quoted in this connexion—before insulin the fœtal mortality rate was 44%; with insulin it was 38%. Since insulin has made pregnancy practically as safe for the diabetic as for the non-diabetic mother, it has been possible to study the effect of diabetes on pregnancy. Unfortunately the matter is not yet clear and the fœtus of the diabetic mother still has a hazardous journey to make before he can pass to an independent existence. The problem to be faced is why the fœtal mortality rate remains high, and until that is discovered the obstetrician must seek some rules to guide him in his efforts to lead the fœtus to safety.

The latest authors to investigate the subject are R. D. Lawrence and Wilfrid Oakley, who write from the diabetic department of King's College Hospital, London.[1] They mention four theories which have been advanced to account for the heavy fœtal mortality. The first has to do with the occurrence of what have been called "giant" babies in diabetic pregnancies. "It is generally agreed that if the pregnant diabetic is allowed to go to term without special supervision, either the baby tends to be over-sized and is often stillborn or, should a live child be delivered, death within 24 or 48 hours of delivery is not uncommon, no obvious cause being present." The size of these babies has been regarded as due to excessive supplies of sugar, which reach the fœtus because of hyperglycæmia in the mother. Lawrence and Oakley agree with this view. They are sure that the fœtus uses an increased amount of sugar because they have sometimes found the maternal glycæmia to be greater than the fœtal, such figures as 180 and 80 milligrammes *per centum* being examples. It has also been suggested that the overgrowth may be due to an excess of pituitary growth hormone. The second cause which has been suggested as possibly accounting for the high fœtal and neonatal mortality rate is fœtal hypoglycæmia. This view, Lawrence and Oakley state, is based on sugar estimations on blood from the umbilical cord and from newly born babies of diabetic mothers and on histological examinations of the pancreas. They refer to the work of several authors on hypertrophy and hyperplasia of the islands of Langerhans in the fœtal pancreas, and add that it has not been possible to correlate the clinical picture, the blood sugar readings and the histological findings. At the same time they point out that improvement in maternal diabetes may occasionally occur in the later months of pregnancy which is not maintained after delivery and is therefore presumably due to fœtal insulin. The third reason advanced for the high fœtal mortality rate is that congenital anomalies are abnormally frequent among babies born of diabetic mothers. Lawrence and Oakley admit this as a contributing cause. The fourth cause "is held to be toxæmia of pregnancy, which is said to be much more common in diabetic than normal pregnancies". Before this important question of toxæmia of pregnancy is discussed it should be pointed out that Lawrence and Oakley base their paper on records of 54 pregnancies, all of which occurred since the introduction of insulin in 44 diabetic women. Only one of the women died, and her death was the result of pulmonary embolism, which occurred twelve days after the performance of Cæsarean section. On the other hand, of 57 babies 21 were either born dead or failed to survive more than a few hours. In their series Lawrence and Oakley noted only the first of the four possible causes mentioned by them. Turning now to the question of toxæmia, we find the present position well summarized in "The Medical Annual" for 1941. It is stated in this summary that a recent paper by White, Titus, Joslin and Hunt raises hopes that the solution has been found. From a consideration of their experience these authors were driven to the conclusion that the death of the fœtus could not be correlated with the state of the diabetes of the mother. They therefore sought for clinical evidence of factors other than diabetes; they found that amongst diabetics there was a high incidence of the toxæmia of pregnancy and that the high fœtal mortality rate was mainly confined to the toxæmic patients. Now Murphy and also Smith and Smith had reported that toxæmia was preceded by a rise in the level of prolan in the serum. White, Titus, Joslin and Hunt tested this observation. They found that in fourteen pregnancies among diabetics whose serum was and remained normal there was one fœtal death, which resulted from *asphyxia pallida* two hours after delivery. In ten pregnancies among diabetic patients whose serum prolan level was above normal there were six fœtal deaths. After this experience a further group of nine patients whose serum prolan level was above normal were given every day

[1] *The Quarterly Journal of Medicine*, January, 1942.

from 150,000 to 300,000 international units of œstrin ("Progynon B") and from ten to twenty milligrammes of progestin ("Proluton"). Eight live births resulted. In the ninth case treatment was stopped, the serum prolan level rose and intrauterine death of the fœtus followed. The reviewer in "The Medical Annual" describes these results as encouraging. At the same time he deplores the high cost of such treatment and hopes that the cheaper synthetic œstrogens may prove to be as effective as the biological product. Though Lawrence and Oakley are interested almost entirely in the poor viability of the oversized fœtus and allow it to dominate their plans of treatment, they do refer to the work of White, Titus, Joslin and Hunt. They state that these observers "present a strong case for the importance of maternal toxæmia in fœtal mortality and its reduction by hormone treatment". Later on they discuss the question of toxæmia more fully. They point out that severe grades of toxæmia with eclamptic or preeclamptic manifestations offer no difficulty in diagnosis and were not seen in any of the cases in their series. Milder forms of toxæmia, in which albuminuria, hypertension and anæmia are the chief signs, are less easily diagnosed in diabetics, because albuminuria and slight œdema are sometimes seen in diabetes uncomplicated by pregnancy and because œdema alone is a common finding in the later months of pregnancy. They therefore diagnosed toxæmia only when all these three signs were present. In only five cases in the series was a diagnosis of toxæmia made on this basis. In these five cases treatment was adopted which consisted of rest, the administration of fluids and a diet with a low protein content. Six live babies resulted (there was one twin pregnancy) and there was no maternal mortality. Lawrence and Oakley point out that these five cases do not lend support to the view that toxæmia of pregnancy is an important factor in the high fœtal mortality rate. They have undertaken no œstrin or prolan analyses because they "have been assured by experts that such analyses are so uncertain and variable as to have no clear significance". This does not of course dispose of the view championed by White, Titus, Joslin and Hunt. Clearly more work will have to be done before finality can be reached.

From the practical point of view there is more to be said. Lawrence and Oakley show that babies can be saved if the pregnancy is supervised throughout and if it is terminated at the thirty-sixth or thirty-eighth week. Forty pregnancies in their series were completely supervised; 42 babies were born and 31 of them were alive. Ten pregnancies were not supervised at all; eleven babies were born and only three of them were alive. It is important to note that a considerable increase in insulin dosage was often necessary during the latter half of pregnancy. Pregnancy produces a lowering of the renal threshold in diabetic women, and this may amount to almost a complete loss of threshold. This may, of course, occur in pregnancy in non-diabetic women. In diabetes it is of importance in regard to ketosis; Lawrence and Oakley find evidence to suggest that severe ketosis of short duration may be an important factor in fœtal mortality. Not only must ketosis and hypoglycæmia be avoided from the maternal point of view; hyperglycæmia must be simultaneously controlled more closely than usual, lest harmful over-development of the fœtus should occur. Generally speaking, Lawrence and Oakley are in favour of Cæsarean section for *primiparæ* and of induction of labour for *multiparæ*. For a detailed account of their views readers are referred to the original paper; but closing reference should perhaps be made to the advisability of pregnancy in diabetes. Since by modern treatment pregnancy has been made practically free from danger to diabetic women, there seems to be no reason from the maternal point of view why it should be prevented. Special conditions may exist which will give rise to a difference of opinion; in these circumstances all the factors will have to be weighed—those associated and those not associated with diabetes—before a decision is reached.

Current Comment.

THE DYSPEPTIC SOLDIER.

THE aphorism that "an army marches on its stomach" has acquired a new meaning during the present war. It was not long before the British Army authorities were facing a problem which had caused no particular anxiety during the first world war. In that war stomach diseases averaged about tenth place in the order of incidence; in the present war ulceration of the stomach and duodenum promises to vie with anxiety neurosis as the prime cause of invalidity. The intervening years have brought with them a vast increase of dyspepsia and in particular of gastric and duodenal ulceration. It is therefore not an unexpected finding that when millions of men and women are suddenly cast into the services to lead a strenuous life and to eat a standardized dietary, to say nothing of their having to face the psychological turmoil inseparable from such an existence, many of those constitutionally predisposed will sooner or later suffer from organic dyspepsia.

Various figures have been given of the present incidence of dyspepsia in the British Army, mainly because military physicians and medical boards have universally been seized with the extraordinary frequency of this complaint. The majority of these records refer to patients seen between the outbreak of the war and January, 1941. One of the largest of such series has recently been reported by Lieutenant-Colonel William Brockbank, Royal Army Medical Corps, "from a military hospital in England", who analysed a series of 10,923 admissions during the first eighteen months of the present war.[1] Obviously he is presenting a cross section of one of the largest military hospitals in the country. Nine hundred and thirty-one of the patients admitted, or 8·5%, were dyspeptics. These patients were put through the same routine procedure. After a careful clinical examination most of them had a bismuth meal and a fractional gastric analysis. Only 5·8% of all dyspeptics were returned to their units after purely clinical examination and treatment. If the X-ray examination and test meal produced normal findings, both the patient and his own medical officer were more satisfied and readmissions were much reduced.

Brockbank has only admitted proved cases of peptic ulcer to his series, and only one case of carcinoma of the stomach was encountered. He states that the vast majority of patients had had symptoms in civil life before entry into the army. The number of patients whose ulcer seemed to have originated during army life was amazingly small—about 1% of all dyspeptics and 2% of all those with proved ulcer. This at once suggests that medical boards at recruiting centres were uncommonly careless in their review of the past health of men and

[1] *The Lancet*, January 10, 1942.

women presenting themselves for service. Brockbank quotes the British Army recruiting instructions, in which a direction is given that a man with a history of ulcer of the stomach or duodenum, or one of its complications, should be rejected or deferred. The recommendation continues: "on the other hand the mere complaint of indigestion with abdominal pain, even if extending over some years, is not a bar to placing the man in the grade for which he is otherwise suitable". These instructions, as many reports like the present have proved, permit the entry of many potential or active sufferers from peptic ulceration. It is easy to be wise after the event, and if all critics, particularly specialists, were allowed full rein we should have an army of supermen, but only a small one.

In Brockbank's experience true malingering was rare, and the characteristic features of the peptic ulcer history together with observation in hospital, sufficed to distinguish the few culprits. The author unfortunately was not able to produce accurate figures of his own to show how long a man with peptic ulcer had been on army service, but he quotes Colonel W. W. Browne, President of the Western Command Standing Medical Board, as stating that about 46% had served more than twelve months, most of whom gave a history of many years' standing. During the early period of training a recruit would often be in a position to modify the army diet to suit his own stomach, but later, when the same facilities were no longer available, symptoms returned and he had to report sick.

One of the striking findings made by Brockbank was that the problem remained at a constant magnitude. It was thought at the beginning that all the dyspeptics would be weeded out, and then the numbers would fall off considerably; but this did not happen. Another notable finding was that his figures agreed closely with those of other naval and military observers, according to which nearly half the men investigated for dyspepsia were proved to have ulceration, usually in the duodenum. In other words, by the time the patient suffered from sufficiently severe dyspepsia to warrant in-patient hospital investigation, there was an even chance that he already possessed a gastric or duodenal ulcer.

The disposal of these patients with proved ulcer has now become the subject of specific War Office instructions. At first it was the custom to return to duty patients with proved ulcer which did not appear to be particularly active. Thus in September, 1939, 50% of the affected soldiers returned to their units. This error was soon corrected, and in October, 1939, only 29% were sent back to duty. For the remainder of the eighteen months under review only 7% returned to duty, and these only had trivial complaints or were privileged patients. In March, 1940, the British Army authorities issued instructions that all men with positive radiological signs of ulcer were to be discharged as permanently unfit for military service. Later, when the condition was clinically one of peptic ulcer, invaliding was recommended. Nevertheless, men with dyspepsia and gastritis, occurring shortly after enlistment, were to be kept at work for a trial period with simple assistance from the unit medical officers, as hospital treatment was not held to assist in adaptation to the service environment. Finally, in February, 1941, a further War Office letter directed that men with chronic conditions who gave a long-standing history and had evidence of physical manifestations of deficient nutrition, anæmia or abdominal tenderness should also be recommended for discharge from the army. Following this rule, 90% of Brockbank's patients with proved ulcer were discharged—a total of 351 cases. Of his remaining 534 men in whom no ulcers were found, 90% were returned to duty and the remaining 10% were discharged on purely clinical grounds. Those men sent to duty very rarely returned. In Brockbank's words, "they seemed to realize that they had had a fair examination and were unlucky. There was nothing else to do therefore but get on with the war."

No further evidence should be required as to the magnitude and importance of the peptic ulcer problem in the services. Those who have had experience in the present trends of health in the services of this country will not be surprised at Brockbank's figures. No doubt Australian statistics of this character will soon be available. Naval and military medical boards in this country have already realized the hopelessness of trying to return patients of this class to duty. Many of the patients, however, are young men in possession of special training and skill who can still be of inestimable value to the country in the field of war production. It is to be hoped that the authorities upon whom the responsibility for finding intelligent and skilled artisans falls, will not overlook the sufferer from peptic ulcer who has been discharged from one of the fighting services. Under the better conditions of home life, with adequate rest periods and periodical medical observation, many of these persons, who are characteristically hard workers, may continue to play important parts in the war machine and become less of a problem to the Repatriation Commission.

THE MODERATOR BAND.

FEW anatomical structures show so much variation between species and within the same species as the moderator band. Certain animals, such as the dog, have no moderator band; in the sheep and pig it is almost invariably present, but differs widely in diameter; in the human and in the cat approximately 50% have this structure. The latest study of this band has been made by R. C. Truex and L. J. Warshaw, of the department of anatomy in Columbia University.[1] These authors have undertaken their investigation from the morphological aspect and they retain the rather old-fashioned view that the moderator band has a physical function to perform in that it prevents over-distension of the right ventricle. It is exceedingly doubtful if this mechanical explanation can be retained today. The attitude of physiologists towards the moderator band took on a totally different complexion when it was shown that this structure carried a main branch of the A-V bundle. Often in the sheep and pig the moderator band contains little else than the Purkinje fibres characteristic of bundle tissue. Again, these authors admit that occasionally a moderator band is found in the left ventricle consisting exclusively of fascicles of left branch A-V bundle. The moderator band is simply a bridge carrying the impulse which sends the cardiac muscle of the external wall of the right ventricle into action. We are beginning to realize what an engineering marvel the heart really is; its economy of energy is truly remarkable, for it makes use of inertia, rebound and resonance effects. Even the small amount of turbulence in the flowing blood is given the task of closing the valves and preventing clack or regurgitation at the onset of systole. The A-V bundle is responsible for the sequence of the contraction in different parts of the heart, and especially is it responsible for the timing of the sequence. In an internal combustion engine we know that much depends on the time relationship of compression to ignition; but this is child's play compared with the timing of the different parts of the heart during contraction. The real problem before physiologists is to explain why one animal or member of a species has a moderator band but another has not. Where no moderator band exists and no departure from perfect functioning of the heart is detectable we must assume that some other device has been employed to distribute the stimulus over the external wall of the right ventricle. As already mentioned, the left ventricle has occasionally a moderator band carrying right bundle fibres. Whether this confers an advantage or begets a disadvantage has not been investigated, but we may assume from the rarity of the occurrence that the left ventricular cycle can be normal in the absence of such a structure. It is surely obvious that the proper approach to the study of the moderator band is in the dynamics of the cardiac engine.

[1] *The Anatomical Record*, March, 1942.

Abstracts from Medical Literature.

OPHTHALMOLOGY.

Sinus Disease and Retrobulbar Neuritis.

ROSA FORD (*The British Journal of Ophthalmology*, February, 1942) reports a case of retrobulbar neuritis in which the etiology was obscure and the condition was for a time suspected of being the first symptom of disseminated sclerosis. Every type of investigation was carried out, including radiological examination of the nasal sinuses; but no abnormality was revealed. Seven months from the onset the decision was made to explore the sphenoidal sinuses, and thick pus was withdrawn from the left and cloudy mucus from the right. Recovery followed when both sphenoethmoidal sinuses were opened, to be speedily followed by a relapse; this yielded to a wider opening of the same sinuses. For a period of five years a series of relapses and recoveries occurred, until finally the antra were opened and found to be full of pus. After the performance of double antrostomy the patient "left the downgrade path for the upgrade", and at the time when the report was written, eleven years after the onset, she had been for some years again an excellent needlewoman. The author stresses the following points: (i) Sinus disease may exist when clinically and radiologically there is no evidence of its presence. (ii) Sinus disease may exist when there is no history of catarrh. (iii) Retrobulbar neuritis may be a symptom of this concealed sinus disease. She concludes that in any case of retrobulbar neuritis in which the cause is obscure, the possible presence of concealed sinusitis should be considered. A preliminary diagnosis can be made by the ophthalmic surgeon from the history and from examination of the visual fields. The reception of a report of negative findings on rhinological examination does not end the ophthalmologist's responsibility, for he alone can request further investigation from a rhinologist. Suction-exploration by Watson Williams's method can give a decisive diagnosis. The patient's recovery after intranasal medication (supplemented if necessary by double antrostomy) may provide sufficient confirmation, and exploration may not be necessary.

JAMES B. COSTEN (*Surgery, Gynecology and Obstetrics*, February 16, 1942) briefly reviews the literature concerning the association of sinus disease with retrobulbar neuritis, and discusses possible etiological factors in the latter condition. He presents several cases in which spheno-ethmoidectomy, either alone or in combination with other therapeutic measures, was followed by improvement in vision. He states that, even though the question should remain open because of many qualifying factors, surgical treatment of diseased sinuses seems to be indicated when the condition occurs in association with retrobulbar neuritis. His experience leads him to believe that the presence of an allergic state increases the indication for surgical measures. Study of records confirms the importance of the removal of foci of infection distant from the optic nerve, such as teeth and tonsils. Laminagrams in the method of Cone, Dean and Moore are useful in the X-ray study of posterior sinus disease. Whatever surgical treatment is used to relieve retrobulbar neuritis or extensive acute retinal lesions, it should be promptly carried out; damage to the optic nerve is rapid and is commonly followed by permanent residual atrophy. The opportunity to show that improvement follows surgical measures is limited, because the cases in which such treatment is indicated are few in number and because all forms of general therapy are used concurrently with surgical treatment. The theories on which rests the idea of the value of surgical measures are four: (i) drainage of infective material away from contact with the optic nerve; (ii) removal of a negative pressure effect in the sinuses causing emigration of toxins and bacteria to the tissues about the optic nerve; (iii) decompression of the nerve; (iv) production of hyperæmia, restoring the blood supply to the nerve. Some authors believe that the same effect can be achieved by the use of stimulating chemicals within the nose, and one at least has taken a strong stand against surgical measures, except for the sake of removal of infective foci as toxic sources.

The Significance of Optic Nerve Lesions.

G. JOLY DIXON (*The British Journal of Ophthalmology*, February, 1942) discusses the significance of lesions of the optic nerve. He states that such lesions generally give both subjective and objective evidence of their presence. Their detection raises the question of their ultimate effect on vision, and also that of the presence of other serious disease. Although certain appearances of the optic papilla are usually associated with one disease, sometimes other diseases cause similar lesions. An isolated lesion occurring in the optic nerve of an otherwise healthy person is considered by many authorities to provide evidence of early disseminated sclerosis. The work of Traquair (1930) suggests that either abortive disseminated sclerosis causes a large proportion of lesions of the optic nerve or some condition exists analogous to disseminated sclerosis but confined to the optic nerve. The author reviews five cases, in which an optic nerve lesion appeared in the absence of any obvious cause and in which observation of the patients for a period of ten years failed to disclose any further abnormality. Extensive investigation of the patients revealed no evidence of disease in the nervous system or elsewhere. It is pointed out that such cases are relatively frequent, as may be judged from the fact that four occurred in a consecutive series of 24 cases of lesions of the optic nerve, discovered when the patients sought advice for failure or abnormality of vision. In the same series there were six cases of disseminated sclerosis and five of tabetic optic atrophy; in only one doubtful case did disseminated sclerosis develop during the period of survey. Eleven of the patients were lost sight of after less than one year, and before any cause for the optic nerve lesion could be established.

The Tonic Pupil Syndrome.

PERCIVAL W. LEATHART (*The British Journal of Ophthalmology*, February, 1942) discusses the tonic pupil syndrome. Since the name gives no descriptive clue to the anatomical position of the lesion, he suggests the use of the term "ciliary ganglion iridoplegia". The lesion is characterized by three physical signs, each pointing to some interference with the nervous mechanism of the internal muscles of the eye: (i) absence or sluggishness of the pupillary reaction to light; (ii) the size of the affected pupil, which is larger than its fellow, but will dilate further in the dark and under the influence of atropine; (iii) slowness of the pupillary reaction to convergence, in spite of the fact that near vision is unaffected. The rest of the eye is normal in all respects. In a certain number of cases the knee and ankle reflexes are absent or diminished. The lesion occurs more commonly in women than in men. The author describes in detail the anatomy of the primary ocular reflexes concerned, and postulates by deduction a lesion capable of producing the physical signs in the eye—a lesion due to defective conduction between preganglionic and post-ganglionic fibres of the ciliary ganglion. If the knee and ankle reflexes are affected in a patient whose pupil does not react to light but does react to convergence, tabes may be suspected. However, a careful examination will reveal physical signs to distinguish the two conditions. In the first place, tabetic pupils are almost invariably bilateral; the tonic pupil is usually unilateral. In tabes, when the knee and ankle reflexes are absent, Rombergism, loss of sensation and absence of the vibration sensation to the tuning fork are present. In the tonic pupil syndrome, although the knee and ankle reflexes may be absent, these other conditions are not fulfilled. If any doubt still exists as to the nature of the lesion, the application of the Wassermann test to the blood serum and to the cerebro-spinal fluid will decide the question. From these facts, and from the well-known nature of the lesion in tabes that affects the knee and ankle reflexes, it is clear that the lesion responsible for the loss of knee and ankle reflexes in the two conditions must have a different situation in each. The author therefore postulates, in the tonic pupil syndrome, a lesion in the sacral and lumbar segments of the cord itself, in the intercalated fibres connecting the posterior root fibres with the anterior horn cells; in other words, he considers that there must be a lesion due to some error of conduction in the synapses in that situation, analogous to that postulated in the ciliary ganglion for the loss of the light reflex. The pathology is not clear and the solution of the problem is a task for the neuro-physiologist.

OTO-RHINO-LARYNGOLOGY.

Prophylaxis of the Common Cold.

T. E. WALSH (*Archives of Otolaryngology*, December, 1941) states that when resistance to the common secondary invaders associated with the advanced stages and complications of a cold can be produced the virus is but short-lived and relatively innocuous. In a series of animal experiments it was shown that a local mobilization of phagocytic cells and tissue antibodies could be produced in the nose by local application of vaccines in the form of nasal drops and that the antibody titre of the nasal mucosa was then higher than that of the spleen or blood serum. By comparison it was found that when the same vaccine was administered by

subcutaneous injection the antibody titre of the nasal mucosa was seldom as high as that of the spleen or blood serum. It was thought, therefore, that the rational method of vaccination against the common cold would be by the direct application of vaccine to the nasal tissues. Polyvalent formaldehyde vaccines were prepared from cultures obtained from the ear, nose and throat clinic. A series of students were used for experimental trial of the value of the nasal vaccine in prophylaxis against colds. Half the number were treated with nightly spraying of the vaccine into the nasal passages and in half a control spray of starch solution was used. The vaccine produced 62% of good results, and 50% of the control patients also reported freedom from colds. A number of the vaccinated subjects reported a feeling of the onset of a cold, but symptoms subsided after twenty-four hours. Also from those who did not use the vaccine in the second year there were reports of as many colds as before, indicating that immunity is not lasting and prophylactic measures need to be repeated.

Ménière's Disease.

A. C. FURSTENBERG, G. RICHARDSON AND F. D. LATHROP (*Archives of Otolaryngology*, December, 1941) report that more than 150 patients with Ménière's disease have been treated in the authors' clinic by the method propounded by Furstenberg, Lashmet and Lathrop in 1934. The results have been so uniformly satisfactory that a statistical compilation is offered from a careful study of patients who have received treatment by the method. By process of anatomical deduction it is considered that the lesion producing the disease is located in the labyrinth. Retention of sodium ions in the cells of the labyrinth, due to either an increased cellular affinity or a sensitivity of certain of the cells to this element, is believed to provide the exciting cause of the attacks. It is claimed that such a hypothesis is not inconsistent with the belief of others that chemical or pressure changes in the labyrinth may be responsible for the attacks. Neither is the theory disproved by the fact that an increase in sodium in the blood has not been observed in sufferers from Ménière's disease. Of 35 patients who had paid return visits to the clinic since treatment based upon the sodium thesis was commenced, six had been treated in the past year, nine had been treated one or two years previously, and twenty had experienced a lapse of three to seven years since the therapeutic procedure had been used. Each had had well-marked and typical symptoms of the syndrome. Twenty-nine patients were entirely satisfied with the response to the therapeutic régime, although nine of these experienced occasional mild dizziness. Six felt that the results were unsatisfactory. Among a further series of 60 patients who were reached by correspondence, 31 reported that they were entirely free from symptoms, a further 20 were greatly relieved, while nine continued to have violent vertiginous attacks. The therapeutic régime, aiming at avoidance and elimination of sodium, is a matter of diet. The value of an initial period of training in the régime, in hospital, is stressed. Intake of sodium is restricted by the avoidance of salty foods, cooking without salt or soda, and abstention from salt at table. In addition, ammonium chloride is given in capsules, six or seven and a half grains each, three times a day with the meals for three days and then omitted for two days. Only a few patients cannot tolerate this medication, and for these exercise, such as brisk walking and judicious starving, may be substituted. The régime is to be strictly observed for six weeks, after which the ammonium chloride may be discontinued. Thence for a further six weeks the salt-free diet is continued, and if the patient is symptom-free, then small amounts of salt may be allowed in cooking. Some, however, appear to be sodium-sensitive and may experience a return of symptoms and so must continue to do without salt. In other instances, too, failure to respond may be found to be due to self-medication with sodium bromide or mixtures containing other sodium salts. Even the water supply may be found at fault and distilled water may have to be used.

Bronchiogenic Carcinoma.

F. R. MENNE AND M. W. ANDERSON (*The Journal of the American Medical Association*, December 27, 1941) reviews the incidence of bronchiogenic carcinoma in the Pacific north-west of America from returns of a *questionnaire* sent to pathologists and from their own personal experience. That better diagnostic facilities and more frequent autopsy examinations explain to some extent the increased recording of primary lung cancer is conceded; nevertheless it is claimed that the figures reveal a true increase in incidence of the disease. In 33,945 post-mortem examinations made between 1920 and 1940 there were 517 instances of bronchiogenic carcinoma (1·52%). When analysis of these returns were made into consecutive five-year periods the number of cases recorded were 3, 63, 201 and 407 respectively. While it is admitted that better diagnostic facilities and the presence of pathologists in institutions which previously had had none must account in part for the great increase in numbers, yet the doubling of the number of cases as between the third and fourth periods is significant and suggests a definite increase in incidence. To ascertain the true explanation of this the yearly percentage of bronchiogenic carcinomata relative to the total number of autopsies performed was studied from the figures of the two institutions in which trained pathologists had been present during the whole twenty-year period. In the Vancouver General Hospital the percentage increased from 1·65 to 2·49, while in the University of Oregon Medical School the rise was from 0·73% to 1·68% of the total number of autopsies. From a study of reports in the literature and from analysis of the statistics under review it is thus concluded that there is both a relative and an absolute increase of bronchiogenic carcinomata. Seeking to explain the increase, inhaled irritants, such as tobacco smoke, exhaust gases from motor cars, industrial dusts, and general contamination of air in congested districts are advanced as reasonable conjectures. It is pointed out, however, that by the time carcinoma of the lung is recognized the lesion is so far advanced that there is considerable difficulty in defining cause and effect. The proportion of males to females was about 5 to 1. Discussing pathology, the authors define two outstanding microscopic types, one in which the major lesion seemed to be a hilar accumulation and the other in which there is found a diffuse involvement without hilar accumulation. Regional pulmonary or lymphatic metastases occur in all instances. Distant metastases were observed in 45 cases. The upper lobe appears to be involved about twice as often as the lower. Microscopically, of 56 cases carefully studied, 31 were of a squamous-cell type, 13 were adenocarcinoma, and eight were of so-called reserve cell type, including three revealing cells of the spindle-cell or oat-cell form.

Diagnosis and Treatment of Cancer of the Larynx.

A. E. HAMMOND (*Archives of Otolaryngology*, January, 1942) compares the statistical reports of a number of other authors with the observations made in 15 cases of cancer of the larynx seen by the author in the past five years. The predominance of males and the age incidence between forty and seventy years are supported by the statistics of the author's series. In one of the fifteen cases cancer had established itself over an irritative thickening of the vocal cord. Heavy smoking and vocal abuse were evident in six of the 15 patients. In 12 cases the location of the lesion was intrinsic, in two others it had been intrinsic but had extended beyond the laryngeal cavity, and in one the primary site was extrinsic. Hoarseness was the principal symptom, and diagnosis was confirmed by biopsy in all cases. Thirteen of the cancers were squamous-cell carcinomata and two papillary carcinomata. Broders's grading according to cell types was sought in all cases, as the author regards this grading as of value in assisting in the selection of treatment, although he concedes that it is not sufficiently accurate alone to form the determining factor. The author, quoting also the opinions of numerous contemporary American laryngologists, regards surgical intervention as the method of choice in the treatment of intrinsic carcinoma of the larynx, laryngofissure for early cordal growths when free mobility remains, and laryngectomy for more advanced cases of relatively low malignancy when fixation of the vocal cords is present. Irradiation is the treatment of choice for extrinsic carcinoma, particularly for tumours of a high index of malignancy. In the present series of 13 cases, 12 were considered suitable for surgical treatment. Laryngofissure was used in eight cases; six of the eight patients were alive and well at the time the author wrote, after intervals of ten months to three years since operation. Of the two who died, one lived for nearly five years, dying of metastases of the left tonsil and lungs, but with no recurrence in the larynx. The tumour had been partly subglottic and of Broders's grade II. This patient had also received a full course of Coutard radiation therapy after operation. The eighth patient in the laryngofissure series died of cerebral hæmorrhage without any evidence of recurrence. Of four patients submitted to total laryngectomy, one developed metastases in the cervical glands five months after operation, two were living and well after an interval of nine months, and one after six weeks from the date of operation. Three patients considered unsuitable for surgery were treated by the Coutard protracted fractional radiation method. One of these had a tumour which had become extrinsic with involvement of the cervical glands. The patient was alive five years after treatment.

Naval, Military and Air Force.

APPOINTMENTS.

THE undermentioned appointments, changes *et cetera* have been promulgated in the *Commonwealth of Australia Gazette*, Number 189, of July 9, 1942.

NAVAL FORCES OF THE COMMONWEALTH

Permanent Naval Forces of the Commonwealth (Sea-Going Forces).

Transfer to Retired List.—Surgeon Lieutenant-Commander Harding Herbert Henshall is transferred to the Retired List, dated 10th May, 1942.

Emergency List

Transfer to Retired List, &c.—Surgeon Commander James Mann Henderson, M.C., is transferred to the Retired List and reappointed for temporary service, dated 17th July, 1942.

Citizen Naval Forces of the Commonwealth.

Royal Australian Naval Volunteer Reserve.

Confirmation in Rank.—Surgeon Lieutenant (on probation) Stanley Earles Craig is confirmed in the rank of Surgeon Lieutenant, with seniority in rank of 12th April, 1941.

AUSTRALIAN IMPERIAL FORCE.

Australian Army Medical Corps.

Captain R. R. Anderson, M.C., is transferred, 23rd April, 1942.

Major C. R. Bloomfield is transferred, 9th April, 1942.

Majors A. D. Byrne and J. S. Crakanthorp are transferred, are appointed to command a Field Ambulance and to be Lieutenant-Colonels (temporarily), 16th April, 1942, and 14th April, 1942, respectively.

Captain (Temporary Major) B. M. Carruthers is transferred and to be Lieutenant-Colonel (temporarily), 15th April, 1942.

Colonel H. C. Disher, C.B.E., relinquishes the appointment of Assistant Director Medical Services, is appointed a Deputy Director Medical Services, is transferred and to be Brigadier (temporarily), 6th April, 1942.

Major F. L. Dods is transferred and to be Lieutenant-Colonel (temporarily), 23rd April, 1942.

Lieutenant-Colonel J. R. Donaldson relinquishes command of a Hospital Ship, is transferred, is appointed to command a General Hospital and to be Colonel (temporarily), 11th April, 1942.

Lieutenant-Colonel A. W. Morrow is transferred, is appointed to command a General Hospital and to be Colonel (temporarily), 23rd April, 1942.

AUSTRALIAN MILITARY FORCES.

Australian Army Medical Corps.

To be Majors (temporarily).—Captains N57715 P. G. Heffernan, 15th April, 1942; and N57720 R. C. Geeves, 5th May, 1942.

Lieutenant-Colonel (Temporary Colonel) E. Culpin relinquishes the temporary rank of Colonel and is placed on the Retired List with the honorary rank of Colonel, 28th April, 1942.

The provisional appointments of Major N270779 J. G. Hunter and Captain N274197 K. S. Jones are confirmed.

Majors E. D. T. Smith and V81460 J. B. Bell are transferred to the Reserve of Officers, 31st May, 1942, and 3rd June, 1942, respectively.

The following officers are transferred from Australian Army Medical Corps Reinforcements, Australian Imperial Force: Captains VX63930 C. N. De Garis and VX68700 L. O. Morgan, 4th February, 1942.

The following officers are transferred from Australian Army Medical Corps, Australian Imperial Force, with regimental seniority in accordance with Army seniority: Captains NX70318 J. A. Bassetti, NX34895 W. Freeborn and NX70988 T. W. Miles, 4th February, 1942, VX14850 T. H. Ackland, 12th April, 1942, and to be Major (temporarily), 19th May, 1942, VX65511 A. R. Wakefield and VX69064 I. H. McConchie, 1st May, 1942, WX29 R. R. Andrew and to be Major (temporarily), 21st May, 1942, and Captain (provisionally) WX3355 B. St. P. Gillett and to be Major (temporarily), 18th May, 1942.

The following officers are transferred: Captains (provisionally) D. B. Wightman, 10th March, 1942, and K. N. Uhd, 20th May, 1942.

Honorary Captain C. R. D. Brothers is appointed from the Reserve of Officers and to be Captain (provisionally), 1st March, 1942, and to be Major (temporarily), 18th May, 1942.

The following officers are appointed from the Reserve of Officers and to be Captains (provisionally): Honorary Captains A. M. Dan, 20th December, 1941, and is transferred, 14th May, 1942, M. L. Verso, 27th February, 1942, M. C. Curwen-Walker and is seconded, 30th April, 1942, N281545 A. D. Shirley, 11th May, 1942, and J. M. Lister, 1st June, 1942.

To be Majors (temporarily).—Captains (provisionally) V6925 A. A. Ferris, 19th May, 1942, K. B. Brown and remains seconded, 29th May, 1942, and N392901 C. F. A. De Monchaux, 1st June, 1942.

To be Captains (provisionally).—Thomas Hugh Donnelly and Roy Keith Constable, 3rd June, 1942; Francis Edison Barclay, 6th June, 1942; and John Byrne with regimental seniority next after Captain (provisionally) F. E. Barclay, 3rd June, 1942.

The resignation of Honorary Captain N. F. Pescott of his commission is accepted, 20th April, 1942.

To be Honorary Major.—Honorary Captain S. Sunderland, 1st May, 1942.

To be Honorary Captains.—Leslie Thomas Jobbins, 28th May, 1942, and Ian Richman Pearson, 31st May, 1942.

ROYAL AUSTRALIAN AIR FORCE.

Citizen Air Force: Medical Branch.

The following are appointed to commissions on probation with the rank of Flight Lieutenant with effect from dates indicated: Justin Richard Vernon Foxton, M.B., B.S. (5254), Russell Hughes Oxby-Donald, M.B., B.S. (5253), 4th May, 1942.

The secondment of temporary Squadron Leader C. H. R. James, M.B., B.S., Royal Australian Navy (5162) ceases, and his appointment to the Royal Australian Air Force is terminated with effect from 13th June, 1942.

The appointment of temporary Flight Lieutenant J. S. Robertson (1611) is terminated with effect from 13th June, 1942.

Gregory John Ramsay, M.B., B.S. (5308), is appointed to a commission on probation with the rank of Flight Lieutenant with effect from 25th May, 1942.

Austin Raymond Farrar (5798) is appointed to a commission on probation with the rank of Pilot Officer with effect from 1st June, 1942.—(Ex. Min. No. 91—Approved 8th July, 1942.)

The probationary appointment of Temporary Squadron Leader J. S. Baird (1481) is confirmed.

The probationary appointments of the following Flight Lieutenants are confirmed: L. C. Stinton (3185), J. B. Cahill (3188), G. Roberts (3189), H. P. S. Simpson (3448).

Pilot Officer J. G. Palmer (2891) is confirmed in his probationary appointment and is promoted to Flying Officer, with effect from 15th January, 1942.—(Ex. Min. No. 93—Approved 8th July, 1942.)

The following Flight Lieutenants are being transferred from the Medical Branch Reserve to the Active List, with effect from 1st June, 1942: H. R. P. Boucaut (2873), R. Byrne (4251), J. H. Isles (3437), H. H. Jackson (1379), N. Morrissy (4850).

The following are appointed to commissions on probation with the rank of Flight Lieutenant, with effect from the dates indicated: Eric Alfred Eddy, M.B., B.S. (5903), Charles Hugh Noack, M.B., B.S. (5904), 1st June, 1942.

Reserve: Medical Branch.

John Dudley Maude, M.B., Ch.M., D.O.M.S., D.O., M.R.A.C.P. (5281), is appointed to a commission on probation with the rank of Flight Lieutenant for part-time duties with effect from 27th April, 1942.

Temporary Flight Lieutenant K. M. Callen (4104) relinquishes his commission with effect from 1st April, 1942.—(Ex. Min. No. 89—Approved 8th July, 1942.)

The following are appointed to commissions on probation with the rank of Flight Lieutenant, with effect from the dates indicated: John Keith Douglas Mackenzie, M.B., B.S. (5910), 3rd June, 1942; William Kendall Collins, M.B., B.S. (5911), 5th June, 1942; John Alexander Shanasy, M.B., B.S. (5935), 8th June, 1942.—(Ex. Min. No. 94—Approved 8th July, 1942.)

CASUALTIES.

ACCORDING to the casualty list received on July 14, 1942, Lieutenant-Colonel T. Hamilton, A.A.M.C., Newcastle, New South Wales, Major R. Dick, A.A.M.C., Balgowlah, New South Wales, Major K. J. Fagan, A.A.M.C., Bookham, New South Wales, and Major W. E. Fisher, A.A.M.C., Rose Bay, New South Wales, are reported to be missing abroad.

According to the casualty list received on July 15, 1942, Captain G. F. Braby, A.A.M.C., Maribyrnong, Victoria, Major K. B. Burnside, A.A.M.C., Toorak, Victoria, Captain A. R. Bush, A.A.M.C., Melbourne, Victoria, Major J. F. J. Cade, A.A.M.C., Bundoora, Victoria, Major I. T. Cameron, A.A.M.C., Croydon, Victoria, Major H. W. Park, A.A.M.C., Melbourne, Victoria, Captain R. R. Paterson, A.A.M.C., Caulfield, Victoria, Major H. A. Phillips, A.A.M.C., Caulfield, Victoria, Colonel D. C. Pigdon, A.A.M.C., Narre Warren, Victoria, Major B. A. Hunt, A.A.M.C., Cottesloe, Western Australia, and Major A. W. Farmer, A.A.M.C., Cottesloe, Western Australia, are reported to be missing overseas.

According to the casualty list received on July 16, 1942, Major H. H. Eddey, A.A.M.C., Footscray, Victoria, Captain A. W. Rogers, A.A.M.C., Elwood, Victoria, Major J. O. Rosson, A.A.M.C., Shepparton, Victoria, and Major J. J. Searby, A.A.M.C., Warracknabeal, Victoria, are reported to be missing overseas.

According to the casualty list received on July 17, 1942, Captain G. D. Cumming, A.A.M.C., Manly, New South Wales, is reported to be missing abroad.

According to the casualty list received on July 20, 1942, Captain C. R. Boyce, A.A.M.C., Goodna, Queensland, Captain A. R. Hazelton, A.A.M.C., Artarmon, New South Wales, Captain P. I. A. Hendry, A.A.M.C., Strathfield, New South Wales, Lieutenant-Colonel W. A. Bye, A.A.M.C., Sydney, New South Wales, Major G. N. S. Campbell, A.A.M.C., Vaucluse, New South Wales, Major F. P. C. Claffy, A.A.M.C., Sydney, New South Wales, Captain F. F. Elliott, A.A.M.C., Merewether, New South Wales, and Major R. E. Maffey, A.A.M.C., Singleton, New South Wales, are reported to be missing abroad.

Post-Graduate Work.

WEEK-END COURSE AT LISMORE.

THE New South Wales Post-Graduate Committee in Medicine announces that, in conjunction with the North-Eastern Medical Association, it will hold a week-end course at Lismore on Saturday, August 1, and Sunday, August 2, 1942. The programme is as follows:

Saturday, August 1, 1942.

At the Lismore Base Hospital.

2 p.m.—General meeting of the North-Eastern Medical Association.

4.15 p.m.—"American Views on the Treatment of Burns", Captain A. Jonas, 118th General Hospital, United States Army.

At the Commercial Hotel, Lismore.

6.30 p.m.—Official dinner.

7.30 p.m.—"Sulphonamide Therapy", Major Thomas McP. Brown, 118th General Hospital, United States Army.

Sunday, August 2, 1942.

At the Lismore Base Hospital.

9.45 a.m.—"Recent Advances in Infectious Diseases", Professor H. K. Ward.

11.15 a.m.—"Recent Advances in Infectious Diseases", Professor H. K. Ward.

2.30 p.m.—"Recent Advances in the Study and Treatment of Rheumatoid Arthritis", Major Thomas McP. Brown.

4.15 p.m.—"Treatment of Cranio-Cerebral Injuries", Captain A. Jonas.

The fee for the course will be one guinea. Those intending to be present are requested to notify Dr. F. L. Nicholl, Honorary Secretary, the North-Eastern Medical Association, Lismore, as soon as possible, also to state whether it is their intention to be present at the dinner.

Correspondence.

ADVERTISING LITERATURE.

SIR: In today's mail we each received two separate envelopes from the same firm containing literature advertising two separate and already well-known products. The paper was of very good quality and the printed matter included a number of photographs and drawings.

In our opinion these two circulars show clearly that this firm is more interested in maintaining its profits in competition with other firms than in conserving the resources and man power of the country to win the war against fascism.

We trust that other medical men will help the country in its hour of need by patronizing those firms who do not so undermine our war potential, especially since most products are advertised in the journal, which is for the moment adequate.

Yours, etc.,

ROBERT J. LONG.
A. H. DOBBIN.

Williamstown,
Victoria,
June 20, 1942.

RICKETS IN AN AUSTRALIAN COMMUNITY.

SIR: In Dr. Maddox's reference to the baby health centre services in New South Wales in his letter in your issue of May 16, 1942, he makes the following statement: "It is sincerely to be hoped that the sisters in charge of these centres will be interested in the clinical and even the radiographic recognition of mild rickets."

One of the functions of the Division of Maternal and Baby Welfare in New South Wales is to supervise the 225 baby health centres and their staff of 200 specially trained nurses. The nursing staff is aware that the occurrence of rickets is possible under any economic conditions and is always on the alert for any deviations from normal. One of the chief objectives of the service is to protect infants from developing rickets and other nutritional disorders. All known protective measures are adopted. For example, to meet the necessity for up to date knowledge, Dr. Clements kindly consented to present the substance of the investigation referred to by Dr. Maddox at a staff lecture more than seven months ago. I do not agree that radiographic recognition of rickets or the use of hæmoglobinometers by the nurses is either desirable or practicable.

Dr. Maddox suggests that "the abandonment of cod liver oil emulsion for accurately measured doses of vitamin *D* and calcium in a cheap form as prophylactics is long overdue". The cod liver oil emulsion used in New South Wales provides doses of vitamin *A* and *D* accurately standardized in international units as well as other valuable properties of fish liver oil. Also it is accepted by authorities on nutrition that cow's milk is the best "cheap form of calcium", 120 grammes of calcium lactate being equivalent to one pint of milk.

Yours, etc.,

GRACE J. CUTHBERT, M.B., Ch.M., M.R.C.O.G.,
Director of Maternal and Baby Welfare,
Department of Public Health.

Sydney,
June 21, 1942.

THE FUTURE OF MEDICAL PRACTICE.

SIR: It appears inevitable that medical practice in this country is gradually altering, partly by economic pressure, partly by war emergencies, and partly by the changing habits and customs of the people.

The process is essentially an evolutionary one, and, much as some might like to lay down a cut-and-dried plan by which an ideal medical service could be arranged, and practically carried out, it appears much more likely that the course of the future will be along paths not previously devised.

One has only to quote the medical coordination committees to show that no mention was made of such in the elaborately worked out plans of the past.

I venture to say that many other developments will evolve to bridge over difficulties which the profession will encounter during later war processes, and eventually when peace comes, we will find other problems and practical difficulties in our path.

These will again require compromises and ironing out at the time, and it is my firm conviction that no system of government salaries *in toto* or national health schemes will solve all our worries. Further thinking will be necessary.

Thanking you for past space on the above subject.

Yours, etc.,

H. T. ILLINGWORTH.

Bruce Rock,
Western Australia,
July 6, 1942.

Australian Medical Board Proceedings.

SOUTH AUSTRALIA.

THE undermentioned have been registered pursuant to the provisions of the *Medical Practitioners Act*, 1919 to 1935, as duly qualified medical practitioners:

Carter, John J., L.L.M.R.C.P. (Ireland), 1937, L.L.M.R.C.S. (Ireland), 1937, D.R.C.O.G. (London), 1939, L.M. (Rotunda), 1939, Munitions Factory.

Cochrane, Elizabeth Rae, M.B., B.S., 1942 (Univ. Melbourne), Children's Hospital.

Young, Barbara Quinn, M.B., B.S., 1942 (Univ. Adelaide), Royal Adelaide Hospital.

Obituary.

FREDERICK GILBEE BENNETT.

WE regret to announce the death of Dr. Frederick Gilbee Bennett, which occurred on July 10, 1942, at Prahran, Victoria.

RALPH WORRALL.

WE regret to announce the death of Dr. Ralph Worrall, which occurred on July 16, 1942, at Elizabeth Bay, New South Wales.

Nominations and Elections.

THE undermentioned has applied for election as a member of the Victorian Branch of the British Medical Association:

Williamson, Catharine McLean, M.B., Ch.B., D.P.H., D.O.M.S., Flat 3, 10, Lascelles Avenue, Toorak, Victoria.

The undermentioned has applied for election as a member of the New South Wales Branch of the British Medical Association:

Morrison, Ian Craig, M.B., B.S., 1942 (Univ. Sydney), Grafton District Hospital, Grafton.

The undermentioned have been elected members of the New South Wales Branch of the British Medical Association:

Brooks, Edward James, M.B., Ch.M., 1920 (Univ. Sydney), State Hospital and Home, Lidcombe.

Dunn, Richard Evelyn, M.B., B.S., 1942 (Univ. Sydney), 213, Burwood Road, Burwood.

Henning, Richard Winston, M.B., B.S., 1942 (Univ. Sydney), Woodland Avenue, Pymble.

Hughes, David Alfred, M.B., B.S., 1939 (Univ. Sydney), 135, Macquarie Street, Sydney.

Jeffery, Jack Albert Houston, M.B., B.S., 1942 (Univ. Sydney), "Walteela", The Park, Parramatta.

Lane, Alan Ingram, M.B., B.S., 1942 (Univ. Sydney), Sydney Hospital, Sydney.

Lowe, Thomas James, M.B., B.S., 1942 (Univ. Sydney), Royal South Sydney Hospital, Zetland.

Owen, Morris David, M.B., B.S., 1940 (Univ. Sydney), Newcastle Hospital, Newcastle.

Robinson, Raymond George, M.B., B.S., 1942 (Univ. Sydney), Royal North Shore Hospital, St. Leonards.

Wallman, Peter Halcomb, M.B., B.S., 1942 (Univ. Sydney), 41, Rosebery Road, Killara.

White, James McBride, M.B., B.S., 1941 (Univ. Sydney), Shire Office, Cowra (Australian Imperial Force).

Medical Appointments.

Dr. Arnold Caddy has been appointed a member of the Council of Public Education, Victoria, as representing agriculture, in accordance with the provisions of section 83, subsection 3, of the *Education Act*, 1928, for the period ending December 31, 1934.

Dr. Elizabeth Rae Cochrane has been appointed a Resident Medical Officer, Royal Adelaide Hospital, Adelaide, South Australia.

Books Received.

"Australia at War", by George H. Johnston; 1942. Sydney: Angus and Robertson Limited. Demy 8vo, pp. 284 with 36 illustrations. Price: 10s. 6d. net.

Diary for the Month.

JULY 28.—New South Wales Branch, B.M.A.: Medical Politics Committee.
JULY 30.—New South Wales Branch, B.M.A.: Branch.
JULY 30.—South Australian Branch, B.M.A.: Branch.
JULY 31.—Tasmanian Branch, B.M.A.: Council.
AUG. 4.—New South Wales Branch, B.M.A.: Organization and Science Committee.
AUG. 5.—Western Australian Branch, B.M.A.: Council.
AUG. 6.—South Australian Branch, B.M.A.: Council.
AUG. 7.—Queensland Branch, B.M.A.: Branch.
AUG. 11.—New South Wales Branch, B.M.A.: Executive and Finance Committee.
AUG. 11.—Tasmanian Branch, B.M.A.: Branch.
AUG. 14.—Queensland Branch, B.M.A.: Council.
AUG. 18.—New South Wales Branch, B.M.A.: Ethics Committee.
AUG. 19.—Western Australian Branch, B.M.A.: Branch.
AUG. 20.—New South Wales Branch, B.M.A.: Clinical Meeting.

Medical Appointments: Important Notice.

MEDICAL PRACTITIONERS are requested not to apply for any appointment mentioned below without having first communicated with the Honorary Secretary of the Branch concerned, or with the Medical Secretary of the British Medical Association, Tavistock Square, London, W.C.1.

New South Wales Branch (Honorary Secretary, 135, Macquarie Street, Sydney): Australian Natives' Association; Ashfield and District United Friendly Societies' Dispensary; Balmain United Friendly Societies' Dispensary; Leichhardt and Petersham United Friendly Societies' Dispensary; Manchester Unity Medical and Dispensing Institute, Oxford Street, Sydney; North Sydney Friendly Societies' Dispensary Limited; People's Prudential Assurance Company Limited; Phœnix Mutual Provident Society.

Victorian Branch (Honorary Secretary, Medical Society Hall, East Melbourne): Associated Medical Services Limited; all Institutes or Medical Dispensaries; Australian Prudential Association, Proprietary, Limited; Federated Mutual Medical Benefit Society; Mutual National Provident Club; National Provident Association; Hospital or other appointments outside Victoria.

Queensland Branch (Honorary Secretary, B.M.A. House, 225, Wickham Terrace, Brisbane, B.17): Brisbane Associated Friendly Societies' Medical Institute; Bundaberg Medical Institute. Members accepting LODGE appointments and those desiring to accept appointments to any COUNTRY HOSPITAL or position outside Australia are advised, in their own interests, to submit a copy of their Agreement to the Council before signing.

South Australian Branch (Honorary Secretary, 178, North Terrace, Adelaide): All Lodge appointments in South Australia; all Contract Practice appointments in South Australia.

Western Australian Branch (Honorary Secretary, 205, Saint George's Terrace, Perth): Wiluna Hospital; all Contract Practice appointments in Western Australia.

Editorial Notices.

MANUSCRIPTS forwarded to the office of this journal cannot under any circumstances be returned. Original articles forwarded for publication are understood to be offered to THE MEDICAL JOURNAL OF AUSTRALIA alone, unless the contrary be stated.

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